

August 1998

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### Recommended Citation

Tuohey, John F. (1998) "Surgical Prophylactics for Ovarian Cancer (SPOC): An Ethical Inquiry," *The Linacre Quarterly*: Vol. 65: No. 3, Article 8.

Available at: <http://epublications.marquette.edu/lnq/vol65/iss3/8>

# **Surgical Prophylactics for Ovarian Cancer (SPOC): An Ethical Inquiry**

by

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During the 1950's, the principle of Totality emerged as an important tool in medical ethics for evaluating the appropriateness of surgical mutilation. One of the early issues ethicists used the principle to address was prophylactic surgery, usually elective tonsillectomies and elective or incidental appendectomies. An ethical consensus emerged that, while neither an elective tonsillectomy nor an elective appendectomy was justified, an incidental appendectomy was permissible. A directive allowing the latter can be found in the 1954 *Code of Medical Ethics for Catholic Hospitals*,<sup>1</sup> the forerunner of the present day *Ethical and Religious Directives for Catholic Health Services*. Since that time, discussions of prophylactic surgery have all but disappeared from the ethical literature, and no subsequent editions of the *ERD* contain any directive on the topic. Today, the issue of prophylactic surgery is once again emerging as a topic among ethicists and medical staff. The discovery that female carriers of *BRCA1* and *BRCA2* germ-line mutation may be at greater risk for breast and ovarian cancer<sup>2</sup> has some physicians and women questioning whether prophylactic surgery to reduce that risk, specifically a mastectomy or a tubal ligation, can be ethically

appropriate. This is especially true with ovarian cancer due to the minimal mutilation entailed with a tubal ligation as compared to the mastectomy to reduce the risk of breast cancer. Both research and strong anecdotal evidence suggest that a tubal ligation may significantly reduce the risk of ovarian cancer by preventing exposure of the epithelium to steroid-rich follicular fluid and reducing circulating levels of pituitary gonadotropins.<sup>3</sup>

The connection between ovarian cancer and a surgical prophylactic for ovarian cancer, what I will refer to throughout as SPOC, is significant. Approximately 2% of all women will be diagnosed with ovarian cancer in their lifetime. Although less common than some other forms of cancer in women,<sup>4</sup> ovarian cancer is a particularly dangerous form.<sup>5</sup> Less than 40% of those women diagnosed with it will survive five years after that diagnosis.<sup>6</sup>

There are approximately 120,000 deaths related to ovarian cancer each year. To emphasize the seriousness of this disease, 20,000 people die each year from the flu, a figure that constitutes a health epidemic. In addition to the morbidity related to the disease, there are serious issues related to its treatment. Despite a variety of interventions for ovarian cancer, none has been shown to be singularly effective. In addition to their unproved effectiveness, each treatment entails its own morbidity.<sup>7</sup>

Clearly, ovarian cancer poses a serious health risk to all women, and especially those who are carriers of *BRCA1* and *BRCA2* germ-line mutation. The ability to reduce the risk of this difficult and dangerous cancer with prophylactic surgery will have a profoundly beneficial impact on the lives of many women.

There are essentially two ethical issues related to SPOC that emerge within the Catholic tradition that must be addressed. First, SPOC entails surgical mutilation. It must, therefore, be justified according to the conditions of the principle of Totality. As suggested above, however, there is not a great deal of literature discussing Totality and prophylactic surgery, and this is limited to tonsillectomies and appendectomies. This may be due to the fact that there have been relatively few opportunities when surgery was of prophylactic value as compared to its use for therapeutic or diagnostic use. Further, recent literature on Totality has tended to focus on theoretical questions, such as what Pius XII meant by the



concept of the total good of the person, or the correct interpretation of ST II-II q. 65, a. 1, rather than on its application to specific surgical interventions.<sup>8</sup> To ask whether SPOC is permissible according to Totality is, in many ways, to raise a new ethical question.

Second, SPOC entails the ligation of the fallopian tube. SPOC not only prevents exposure of the epithelium to steroid-rich follicular fluid and reduces circulating levels of pituitary gonadotropins. It also results in the obstruction of that sperm and ovum transport necessary for fertilization. As a sterilizing procedure, SPOC cannot be justified simply on the basis of the total good of the person. Direct sterilization, even for the health and well-being of the individual, cannot be licitly performed in a Catholic health care facility.<sup>9</sup> SPOC interventions will only be permissible if the sterilization is an unintended effect of a licit medical procedure. It is therefore necessary that the conditions of Double Effect be met before SPOC can be judged as a permissible medical procedure.

Given these ethical concerns, the place of SPOC within Catholic health care is at best uncertain. The risks and dangers of ovarian cancer and its treatment as well as the reported reduction in risk through SPOC suggest, however, that its place be investigated. Is it permissible to perform the procedure in a Catholic health care facility? May a Catholic physician perform SPOC? May a Catholic woman request SPOC? May an IRB at a Catholic health care institution approve a SPOC protocol? It is the purpose of this work to investigate these questions by examining the procedure within the context of both the principles of Totality and Double Effect. This will be followed by concluding remarks intended to invite further debate. It is my hope that, as with past questions of prophylactic surgery, a consensus may begin to emerge as to the place of SPOC within the Catholic health care tradition.

### **SPOC and the Principle of Totality**

The principle of Totality has become such a part of medical ethics that it is rarely discussed in contemporary literature to the degree that it was earlier in the tradition. Summary statements with a brief history are common today, and deemed sufficient.<sup>10</sup> This is

understandable. As principles become better understood there is less controversy in their application and less need for discussion. SPOC, however, entails at least four issues that may suggest controversy:

(1) the mutilation is for a prophylactic, rather than curative, purpose, (2) it will be difficult to determine that the good end is commensurate to the mutilation required to achieve it, and, finally, SPOC involves a (3) healthy and (4) reproductive organ. Each of these potential difficulties will be addressed here.

Before doing so, a brief word should be said about Totality in general. The principle of Totality, rooted in the work of Aquinas<sup>11</sup>, has come to be understood within the tradition as meaning that true bodily "parts" exist not for themselves, but for the sake of the whole.

As a result, bodily "parts", meaning those organs that do not have ends outside the whole – seemingly excluding the reproductive organs – may be sacrificed for the sake of the whole when there is a proportionately grave or commensurate reason for doing so. That is, there must be a sufficiently grave threat to the person such that a commensurate relationship exists between the good to be gained and the mutilation caused.<sup>12</sup> One important contributor to the development of the principle within the tradition, Gerald Kelly, S.J., elaborates on this point. Kelly makes it clear that the degree of mutilation entailed in surgery is not a decisive element in decision making. As long as there is a commensurate relationship between the mutilation and the good end, the degree of mutilation may be great or slight. What is critical in moral evaluation is the presence of a proportionately grave reason for inflicting the mutilation.<sup>13</sup> This is important to keep in mind. The central ethical element of Totality is the judgment that the mutilation is commensurate to the good end to be achieved. Generally, this judgment requires an examination of the threat to the whole person and the degree and effect of the mutilation required to respond to this threat.

### **(1.) Prophylactic Mutilation**

In addressing the first issue, it needs to be made explicit that surgical mutilation is not limited to those cases where it will serve to cure or manage a present pathology. Totality has also been used to



justify non-therapeutic physical mutilation such as that found in experimentation<sup>14</sup>, and, important for this discussion, as a prophylactic against some possible future disease. Explicitly referring to prophylactic mutilation, Pius XII stated:

Because he is not a user and not a proprietor, an individual does not have unlimited power to destroy or mutilate his body or its functions. Nevertheless, by virtue of the principle of totality and the right to use the services of the organism as a whole, each person can permit individual parts to be destroyed or mutilated when the good of the whole requires it. Further, he may do so to the extent necessary. This may be done *to ensure* life, as well as *to avoid* or, naturally, repair serious and lasting damage that cannot otherwise be avoided or repaired.<sup>15</sup>

(Emphasis added)

Ethical discussion of prophylactic surgery, some of which will be cited here, shows clearly that the phrases "to ensure" (*pour assurer*) and "to avoid" (*pour eviter*), are understood to refer to prophylactic mutilation in the strict sense. Acceptance of certain clinical practices also points to this fact. Immunization is a common example of a prophylactic mutilation held to be commensurate to a good end. The removal of adenoids during a tonsillectomy or the removal of an appendix during abdominal surgery are other, less common instances of a surgical prophylactic that have been justified using Totality. In some medical interventions, the mutilation entailed is easily regarded as commensurate to the good end. In the absence of actual harm, however, it can be difficult to determine whether a proportionately grave reason exists to perform the surgery. Nevertheless, such mutilation is allowed by Totality when there is a proportionately grave reason.

## **(2.) Determining Commensurate Reason**

There is always a degree of uncertainty in making the judgment of commensurate reason when using the principle of Totality. An elderly person with multiple and serious health difficulties may judge that the amputation of a leg is not commensurate to the prevention of gangrene poisoning, whereas a

younger person in otherwise good health may judge the loss of a limb as commensurate. In certain circumstances, either of these judgments could change. The judgment of commensurate reason is not always self-evident, nor universally agreed upon. This is especially true in cases of prophylactic surgery when one must take into account not only the seriousness of the pathology, but also the degree of probability or likelihood that the pathology will come to pass.

One excellent example of the ambiguity in making this judgment concerns the question of a prophylactic tonsillectomy. Charles McFadden, O.S.A., wrote, "it is evident that ordinarily there is no moral justification for the removal of healthy tonsils."<sup>16</sup> The reason, he explained, is because their removal in a moment of pathological crisis is relatively simple. However, there might be situations in which one could justify their prophylactic removal in light of the fact that a tonsillectomy entails only minimal risk to the patient. He gives the example of a poor family of five children who is moving to a new state, and a physician who is willing to perform the procedure free of charge before they move, in anticipation of the possibility of incurring the expense later. Others objected to this conclusion. Kelly is one example, maintaining that because the tonsils are easily removed when necessary, removing them without medical indication "creates risk without proportionate cause."<sup>17</sup>

This lack of certainty does not mean that Totality cannot allow mutilation, either for cure or for prophylaxis. Commensurate reason need not be immediately self-evident or certain. To make these types of judgments, the tradition relies on probable certitude.<sup>18</sup>

Probable certitude simply means that it is reasonable to make the judgment that there is a commensurate relationship between the good end and the surgical mutilation.<sup>19</sup> This is true even if another reasonably judges otherwise.<sup>20</sup> Probable certitude rooted in a reasonable judgement that the good outweighs the harm is sufficient within the moral tradition to allow surgical mutilation. This point is illustrated clearly by the lack of precise analysis in the literature discussing prophylactic mutilations.<sup>21</sup> The determination of commensurate reason is one that conforms to a reasonable judgment, not a precise methodology.<sup>22</sup>

It must be noted that as a consensus emerges regarding a



judgment of commensurate reason in specific situations, it can become difficult or even impossible to reasonably judge otherwise. This is what happened in the case of an elective tonsillectomy. A medical and ethical consensus emerged that it was not reasonable to judge that the procedure entailed a commensurate good. In the absence of such a consensus, however, all that the tradition requires in the application of totality is the reasonable judgment that a proportionally grave reason exists.

### **(3.) Mutilation of Healthy Organs**

A third issue concerns the mutilation of healthy organs. Totality does not restrict mutilation to unhealthy organs, or to organs that are in immediate danger of becoming pathological. Healthy organs may be mutilated for the good of the whole whenever their functioning poses a physical risk to the person. In a 1953 address, Pius XII stated that the decisive element of Totality was not that the organ which is removed or rendered nonfunctional is itself diseased. Rather, the decisive element is that the preservation of that organ or its functioning poses a direct or indirect threat to the body as a whole.<sup>23</sup> When, by its function, a healthy organ exercises a harmful effect on the body and the removal of that organ or the suppression of its function may prove to be of benefit, that organ may be removed or rendered nonfunctional. This applies, and here the fourth issue is addressed, to the reproductive organs as well.

### **(4.) The Mutilation of Reproductive Organs**

Direct sterilization is prohibited within the tradition. This is because only those organs which do not have an end outside the whole person may be mutilated for the sake of the person. The reproductive organs are not understood to function for the direct, physical well being of the person, but rather for the end of procreating another being. They therefore cannot, as seen above, generally be mutilated for the good of the whole. This does not mean that they may *never* be mutilated for the sake of the whole. Reproductive organs may be mutilated for the sake of the whole person as long as it is the general biological functioning of those



organs which affects or threatens the whole, and not their reproductive functioning.

For example, the tradition holds that healthy testicles may be removed if the production of testosterone poses a health risk to a man with cancer.<sup>24</sup> The production of testosterone is necessary for procreation, but in this case it is the testosterone by itself, apart from its reproductive role, which poses a threat to the person. On the other hand, if pregnancy were to pose a health risk to a woman with hypertension, it would not be permitted to mutilate the reproductive system. In this latter case, it is pregnancy, the reproductive functioning of the reproductive organs, that poses a health threat.<sup>25</sup>

### **Totality and SPOC**

Is it possible to make the reasonable judgment that, in light of the degree of risk and morbidity associated with ovarian cancer and its management, and the degree of mutilation entailed in SPOC, there can be a commensurate reason to permit the procedure according to Totality? Is it possible that both a medical and ethical consensus may emerge that such is the case? The consensus that has emerged within the tradition regarding an incidental appendectomy offers a helpful analogy.

Kelly offered what became the standard use of Totality for a discussion of the appropriateness of the incidental appendectomy. He asserted that, (a) when the abdomen was open for some other legitimate reason, (b) because the appendix served no significant role in the functional integrity of the body, and (c) if the appendectomy would not increase the risk of the operation or add a notable inconvenience in convalescence, "there is no moral objection to incidental appendectomy"<sup>26</sup> Using similar arguments, Thomas O'Donnell agreed.<sup>27</sup> It should be pointed out that in stating his conclusion, Kelly does not require that the appendix be pathological. In fact, he explicitly rejected the argument of Nicholas Lohkamp that a purely prophylactic surgery was never permissible. Lohkamp stated that there must be at least the probability that the pathology is already present in some latent or potential way for the incidental appendectomy to be permissible.<sup>28</sup> Kelly comments that this is an interesting theory, and acknowledges that "[i]t may well be that most

apparently healthy appendices are already somewhat diseased." But, "this is not a requisite either morally or medically, for justifying incidental appendectomy."<sup>29</sup> According to the tradition, it is sufficient that there be merely a risk to the health of the person, a risk which he does not specify beyond the acknowledging that "this is fairly routine practice in good hospitals."<sup>30</sup> All that is necessary to justify prophylactic surgery according to Totality is the reasonable judgment that the risks of the procedure, the importance of the organ and the mutilation and physical loss entailed are commensurate to the elimination of risk.

Kelly incorporated this conclusion in his *Code of Medical Ethics*, written on behalf of the Catholic Hospital Association. It can also be found in his *Ethical and Religious Directives for Catholic Hospitals* (Directive 41), approved by the Bishops of the United States "as the official medical code subject to the approval of the authorities for use in their dioceses."<sup>31</sup> This directive was deleted during draft revisions to the *ERD* in 1970, and is not found in the final edition that was approved in 1971. Similarly, it is not found in the recently promulgated 1994 edition. I have been unable to determine the exact circumstances of the deletion. It appears, though, that there is no ethical discussion of the incidental appendectomy in the literature appearing after the time of the publication of Kelly's *Medico Moral Problems*. This may be seen as indicative of a consensus of ethical agreement that the performance of an incidental appendectomy, and the rationale to explain it, is consistent with the tradition's understanding of Totality.<sup>32</sup>

From the above, I believe it can be confidently concluded that the tradition's use of Totality allows prophylactic surgery in those cases where there is a risk to the health of the person posed by the functioning of a healthy organ, and when it is reasonable to judge that there is a commensurability between the mutilation and the reduction or elimination of that risk. From this, I will propose that SPOC can be reasonably judged to be permissible in a way similar to the judgment that an incidental appendectomy is permissible. I will further suggest that, although a consensus exists that an elective appendectomy is not permissible, SPOC need not be restricted to being an incidental procedure. Ovarian cancer clearly poses a more significant health risk than appendicitis, even if the incidence is



lower. Approximately 7% of the population will experience an episode of acute appendicitis requiring an appendectomy. This compares to 2% of the female population being at risk with ovarian cancer. However, it must be kept in mind that appendicitis is generally completely resolved at the time of the episode. Ovarian cancer cannot be resolved at the time of diagnosis, and its management is uncertain and entails significant morbidity. Death and serious complications due to appendicitis are relatively uncommon, yet 60% of those diagnosed with ovarian cancer will die within four years of diagnosis. Also, SPOC, because it entails a relatively simple procedure involving the fallopian tubes, can be performed as an elective procedure as laparoscopic surgery under a general or local anesthesia, or incidentally as part of a cesarian or other abdominal surgery. This is not the case with a prophylactic appendectomy, which ethical consensus holds can only be justified when performed incidentally due to the risks entailed. The overall physical mutilation required for SPOC is smaller than that required by an appendectomy, and in some cases may be reversible.

I will propose, then, that the mutilation and the reduction in risk provided by SPOC with the incidence of ovarian cancer and its attendant morbidity, as well as the morbidity of its treatment makes it reasonable to conclude that SPOC can be justified according to Totality. It still remains, however, to address the issue of sterilization as an effect of SPOC. This will be done through a discussion of the four conditions of the Principle of Double Effect.

### **SPOC and the Principle of Double Effect<sup>33</sup>**

The first condition of the PDE holds that the end or purpose of the procedure must be good. Here, there is no ethical difficulty with intending the preservation of a woman's health as an end. The tradition has long held that the health and well-being of the person is a good end that may be intended as an end. Indeed, right stewardship over the body requires one to intend health and well-being as an end.<sup>34</sup>

The second condition holds that the procedure must be morally good or indifferent. To determine this, it is necessary to specify the moral object of the procedure. In doing so, it should be

noted that there are two immediate effects of SPOC. One effect is the prevention of exposure by the epithelium to steroid-rich follicular fluid and the reduction of circulating levels of pituitary gonadotropins. A second effect is the prevention of sperm and ovum transport through the fallopian tube. These are two distinct biological effects that are related to each other by the fact that each requires a patent fallopian tube. The fallopian tube serves as a transport medium in two different and distinct biological events,<sup>35</sup> and hence its mutilation will result in two distinct biological effects. It is the first effect that reduces the risk of ovarian cancer. It is therefore this effect which lies within the intention (*ex intentione*) as the moral object of SPOC. Sterilization is not the sole immediate effect of SPOC. It is a second effect which, when SPOC is performed as a prophylactic against ovarian cancer, lies outside the intention (*praeter intentionem*). Performed for the purpose of preventing ovarian cancer, SPOC can rightly be said to have a morally good or at least neutral object, and hence is a morally permissible procedure.

The third condition holds that the good effect must not flow from the evil effect. Although similar, this condition is distinct from the second. Even if the procedure is good in itself, it is important to determine that the evil effect of that procedure is not the means to a good end. As already noted in the above discussion of the second condition, both effects flow immediately from the procedure and independently of each other. This biological independence demonstrates that sterilization is neither the object of the act nor the cause or means of the good end. Stated differently, the effect of sterilization is not a means for which SPOC is performed. It is an effect in spite of which SPOC is performed. Preventing pregnancy will not reduce the risk of ovarian cancer.<sup>36</sup>

The fourth condition requires that there be a commensurate reason for causing the unintended effect of a good act. It is one thing to say that the mutilation entailed in SPOC is commensurate to the prevention of ovarian cancer. It must still be determined that this good end is commensurate to the effect of sterilization. Not only must there be a commensurate reason to mutilate the fallopian tube. There must also be a commensurate reason for bringing about the unintended sterilization.



Health and well-being have consistently been understood within the tradition as being commensurate to the mutilation of the reproductive faculty when pathology is present.<sup>37</sup> A caution must be raised here, however, because SPOC pertains to a situation in which there is no pathology present. Instead, it is the risk of a pathology that is of concern. Given the fact that ovarian cancer is a particularly dangerous form of cancer responsible for 120,000 deaths each year, however, it is possible to propose that sterilization as an effect of preventing a pathology may be understood to be analogous to the sterilization that results from treating a pathology. I propose that it is reasonable to conclude that the good end of significantly reducing the risk of a pathology like ovarian cancer is commensurate to the unintended effect of sterilization. There is no certain answer in this case. There is seldom absolute certainty in making a judgment regarding the presence of commensurate reason in this fourth condition of PDE, just as there is often a lack of absolute certitude in making a judgment of commensurate reason with Totality. Still, the prudent person, weighing the facts of the case, might conclude that it is reasonable to judge that a commensurate reason exists for causing sterilization in a prophylactic procedure such as SPOC. The reasonableness of this judgment can be strengthened if the moral significance of that effect is lessened. The possibility of this is rooted in the Church's teachings on Natural Family Planning.

The moral tradition has understood that there are legitimate motives for a decision to positively exclude the good of procreation from the conjugal relationship. Among these are reasons of health, the desire to avoid passing on a genetic anomaly, economic considerations and social mission. When conditions such as these are present, a couple may limit the number of children they will bear as long as in doing so they do not directly intend to impede the procreative end of the sexual act.<sup>38</sup> When there are serious reasons for positively excluding the procreative end from the sexual act, the unintended loss of the reproductive function resulting from a medical intervention directed toward some disease may be more readily judged as being commensurate to a good end. That is, if a couple makes a positive decision not to bear children, and this decision is made with an honorable motive, the unintended loss of fertility that results from some medical procedure either person might have is less

grave from a moral perspective than if the couple simply did not want any children in the first place. In both cases the loss of fertility may be unintended, but the commensurate reason for allowing that unintended effect is different. An example can be found going back to Pius XII's justification of castration in the case of cancer.<sup>39</sup> In the case of a man who, with his wife, has determined not to bear further children due to the presence of a genetic anomaly, the loss of the reproductive function due to castration is less morally grave and thus more readily justified than in the case of a man who has no reason not to procreate and most likely would procreate were it not for the unintended effect of the castration. This is perhaps not the best example, for in both cases the unintended loss of fertility is justified. Nevertheless, the point should be clear that the moral justification in both cases is different. Perhaps a better but admittedly self-serving example is SPOC itself. For a woman who will no longer bear children due to age or health, the loss of fertility is more readily justified than for a young woman who has not borne any children and who has no particular reason why she would not have any. In this case, the risk of ovarian cancer is such that it would be difficult to see how the unintended loss of fertility could be justified as being commensurate to the good end

### Conclusion

SPOC, performed for the good end of health, has as its moral object the prevention of exposure of the epithelium to steroid-rich follicular fluid and the reduction of circulating levels of pituitary gonadotropins. Sterilization results as an unintended effect that is not the cause of the good end. As such, SPOC meets the first three conditions of Double Effect and may be described as a permissible prophylactic surgical intervention. Before SPOC may be performed in any given case, however, both the requirements of Totality and the fourth condition of PDE must be satisfied. It must be reasonable to judge that both the mutilation entailed and the effect of sterilization that results are commensurate to the good end of significantly reducing the risk of a dangerous cancer.

With regard to commensurate reason and Totality, I propose that the incidence and morbidity of ovarian cancer and its



management, seen within the context of the significant reduction in risk, make it reasonable to conclude that the minor mutilation involved in SPOC is commensurate. The use of surgery as a prophylactic against ovarian cancer may be said to be justified by Totality. This is especially true when SPOC is performed as an incidental rather than elective procedure. In light of the comparatively less mutilation entailed in SPOC as compared to an appendectomy and the fact that SPOC can be done as a laparoscopic procedure in an outpatient setting, this restriction to incidental use may not be necessary with SPOC. Some will disagree with the reasonableness of either or both of these judgments. In the absence of a consensus, which this work seeks to help shape, it is nevertheless possible to hold that this conclusion is probable.

With regard to the fourth condition of the PDE, the tradition would generally hold that the good end of health is commensurate to the unintended effect of sterilization. This is especially the case when there is some reason, such as those articulated by Pius XII, which allows a couple to positively exclude the procreative good. Hence, it seems reasonable to judge that the loss of fertility entailed in SPOC is allowed for a commensurate reason. The reasonableness of this conclusion can be strengthened in those instances when the moral significance of the loss of fertility is mitigated by some serious reason. This would not appear to be a necessary restriction, but rather a prudent application in light of the fact that the procedure is prophylactic rather than curative.

I will tentatively conclude here that SPOC is not in any way prohibited by the tradition as a whole, or by any specific directive of the *ERD*.<sup>40</sup> It would seem that SPOC may be performed in a Catholic facility as part of a research protocol to confirm its prophylactic value, or simply at the request of a patient. Similarly, a Catholic woman is free to request SPOC of her physician, and a Catholic physician or nurse is free to perform or assist in SPOC in a non-Catholic facility. In light of the fact that the judgment regarding a commensurate reason in both Totality and the fourth condition of the PDE is formed with probable certitude for which a consensus does not yet exist, hospital policies may want to limit the general use of SPOC to situations wherein it can be performed concurrent with an otherwise medically indicated surgical procedure, and when there

is some reason to avoid future procreation. Nevertheless, policies should not be closed to the possibility that in some hospital settings and under some circumstances SPOC can be permissible outside the context of some other surgery or serious reason to exclude procreation. Using Kelly's expression regarding elective appendectomies, there can be special cases in which this use of SPOC would seem probable.<sup>41</sup> These can be addressed on a case by case basis until such time as a consensus begins to emerge regarding this judgment.

This conclusion is based on what appear to this author to be reasonable judgments of what constitutes a commensurate reason for performing SPOC. The reasonableness of this judgment depends on both ethical and medical information. It is necessary, as ethicists seek to build a consensus, that policies that allow SPOC and decisions of conscience which inform individuals' behaviors be continually reviewed. Medical information may come to light that challenges or strengthens the judgments put forth here. It must be kept in mind that changes in the medical information may make SPOC more easily justified, less easily justified, or even prohibited.<sup>42</sup>

In the meantime, it seems reasonable to conclude that SPOC is a generally permissible prophylactic procedure for ovarian cancer. I invite other ethicists to join me in this discussion so that a clearer consensus may emerge in a manner similar to the consensus that now informs Catholic health care's acceptance of the incidental appendectomy.

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9. *Ethical and Religious Directives for Catholic Health Care Services*, No. 53.

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10. See, for example, Benedict M. Ashley, OP; Kevin O'Rourke, *Healthcare Ethics: A Theological Analysis*. 3rd edition. St. Louis, The Catholic Health Association of the United States, 1989.

11. *ST II-II Q.65*, a.1.

12. See Pius XI, "Cast Connubii, AAS 22 (1930) 559ff; Pius XII, AAS 44(1952) 779-89. For a discussion of Totality within the tradition, see J.J. Lynch, "Totality, Principle of", *The New Catholic Encyclopedia* vol. 14, New York, McGraw-Hill, 1967, pp. 211-12; John Gallagher, "The Principle of Totality: Man's Stewardship of His Body", in *Moral Theology Today*. Certitude and Doubts, ed. Donald McCarthy, St. Louis, Pope John XXIII Medical-Moral Research & Education Center, 1984, pp. 222-24. The ERD speaks of the bodily and functional integrity of the person at no. 29.

13. Gerald Kelly, S.J., "Medical-Moral Notes", *The Linacre Quarterly* XX (Nov 1953) 116-117. See also Pius XII AAS 44 (1952) 782.

14. See Pius XII, AAS 44(1952) 779; AAS 46 (1954) 587.

15. Pius XII AAS 44(1952) 782. Today, any mutilations done for reasons of health that are performed for a proportionately grave reason are said to be justified, whether they be prophylactic, diagnostic, therapeutic, prosthetic, or palliative. Purely cosmetic mutilations, as opposed to re-constructive surgery, remain a matter of debate.

16. Charles McFadden, O.S.A., *Medical Ethics*, third edition, Philadelphia, F.A. Davis Company, 1953, p. 292.

17. Kelly, *Medico Moral Problems* 260. See also Thomas J. O'Donnell, *Morals in Medicine*, Westminster, MD, The Newman Press, 1956, D. 81.

18. See S.T. II-II, q.70, a.2. See also Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning*, Berkeley, University of California Press, 1988, esp. pp. 164-75, 250-65.

19. See Pius XII, AAS 45 (1953) 674.

20. See Henry Davis, *Moral and Pastoral Theology*, 2nd edition, New York, Sheed and Ward, 1952, at page 78. See also Jonsen and Toulmin, *The Abuse of Casuistry*, 165.

21. For an example, see Kelly's agreement with McFadden (McFadden, *Medical Ethics*, pp. 292-93) that "[t]here are some special cases in which it seems probable



that an individual may justifiably ask for an appendectomy, even though no medical indications are actually present." Kelly, *Medico Moral Problems*, p. 253-54. See also Francis Connell, "Surgery for the Healthy", *American Ecclesiastical Review*, February, 1947, p. 143. For each of these authors, the general prevalence of appendicitis is cited rather than the statistical probability that varies at different ages. For McFadden and Connell, general economic considerations could make the elective procedure permissible. For Kelly, the fact that one is doing missionary activity or special military service in locations where quality health care may not be readily available could make the elective appendectomy permissible. These are judgments based on a general sense of what might be considered reasonable, rather than on a technical and precise analysis.

22. It is interesting to also cite the debate at this time regarding the performance of a hysterectomy in cases of a uterus that was in danger of rupture during pregnancy.

Kelly holds "the practical probability of the opinion" that this is permitted. Other authors who agree include John R. Connery, S.J., *Theological Studies*, (1955) 575-76, John J. Lynch, S.J., *Theological Studies* (1957) 230-32, speaks of the "solid probability" of this opinion; McReavy, LL, *The Clergy Review* (1956) 485-89 speaks of the "extrinsic probability" of this opinion; O'Donnell, *Morals in Medicine*, 108-110 cites opinions for and against the hysterectomy, but favors the affirmative opinion as probable.

23. Pius XII *AAS* 45 (1953) 674. See also Pius XII, "An Address to a Symposium of the Italian Society of Anesthesiology." *The Pope Speaks* 4(1958) 349.

24. Pius XII *AAS* 45 (1953) 673-79. See also Gerald Kelly, S.J., "Pope Pius XII and the Principle of Totality," *Theological Studies* 16 (1955) 373-96.

25. See "Responses on Uterine Isolation." *Origins* 24, (1994) 211-12.

26. Kelly, *Medico Moral Problems*, 252.

27. O'Donnell, *Morals in Medicine*, p. 81

28. Nicholas Lohkamp, *The Morality of Hysterectomy Operations*, The Catholic University Press, Washington, D.C. 195 p. 139, note 135.

29. Kelly, *Medico Moral Problems*, 253.

30. Kelly, *Medico Moral Problems*, 253.

31. Minutes of the 36th Annual Meeting of the Bishops of the United States, November, 1954.

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32. According to both James Keenan, S.J., and Thomas Kopfensteiner, consultants to the NCCB for the 1994 edition, the issue of prophylactic surgery was not discussed. Both agreed that this was probably due to a presumed consensus on the appropriateness of the practice and the rationale that informed it. Personal conversation, 6 and 17 January, 1997.
33. See J.P. Gury, *Compendium Theologiae Moralis*. New York, Benzinger, 1874, "De actibus humanis," tr. 1,c. 2,n.9; Herbert C. Kramer, *The Indirect voluntary or Voluntarium in Causa*. Washington, D.C., Catholic University of America, 1935; Joseph T. Mangan, "An Historical Analysis of the Principle of Double Effect." *Theological Studies* 10 (1949) 41-61; F.J. Connell, "Double Effect, Principle of" *The New Catholic Encyclopedia* vol. 4, pp. 1020-22.
34. See the *Catechism of the Catholic Church*, no. 2288.
35. The distinctiveness of these events is further evidenced by the fact that during the period of the flow of steroid-rich follicular fluid, no ovum is available.
36. This is unlike the case of uterine isolation in which it is the prevention of pregnancy that prevents the event of uterine rupture. (See "Responses on Uterine Isolation.") In the case of a weakened uterus, the risk of rupture exists solely during pregnancy. Hence, the prevention of uterine rupture is medically and morally tied to the prevention of pregnancy. With ovarian cancer, the risk is independent of pregnancy. There is no known connection between pregnancy and the risk of ovarian cancer. Hence, the prevention of ovarian cancer is medically and morally independent of pregnancy.
37. See, for example, Paul VI, *Humanae Vitae*, no. 15; "Ethical and Religious Directives for Catholic Health Care Services," no. 15.
38. For this discussion, see Pius XII, "Address to the Italian Midwives," *AAS* 43 (1951), esp. pp. 835-54.
39. *AAS* 45 (1953) 673-79.
40. Such a conclusion remains open to affirmation or correction by subsequent teachings.
41. See Kelly, *Medico Moral Problems* 254. For example, a woman whose family history suggests she may be at higher risk for cancer might desire SPOC independently of some other surgery.
42. One development which could impact on this judgment may come from research now being done to determine the feasibility of laparoscopy staging patients with incompletely staged cancers of the ovary, primary fallopian tube



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carcinoma and primary peritoneal carcinoma. Better staging of these cancers could lead to better treatment regimes. However, care must be taken not to respond too quickly to medical information, or to impose too high a standard for what constitutes a reasonable judgment of proportionately grave reason. McFadden bases his judgment regarding an incidental appendectomy in part on the claim that nearly 20% of the population will experience appendicitis. (McFadden, *Medical Ethics* 292) That figure is now known to be only 7%, yet this dramatic change in risk has had no impact on the moral assessment of the procedure. Kelly uses no statistical information. In fact, when discussing the factors that must be taken into account in making a decision in favor of an incidental appendectomy, he makes no reference at all to the actual risk of having appendicitis. (Kelly, *Medico Moral Problems* 252) In spite of these lacks, he is still able to come to his conclusion.